**RESEARCH ARTICLE**

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# A death in the family: Citizens' experiences of changing healthcare commissioning practices in South East England

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**Abstract**

The Brighton Citizens Health Services Survey was an academic activism project to identify and understand citizens' perceptions of and responses to healthcare commissioning practices. Significant legislated changes to the National Health System (NHS) across England have increased marketisation in healthcare provision, yet little research has explored the psychological dimensions of this shifting context and its community impact. Taking a community psychological perspective to social policy, we aimed to understand lay citizens' lived experience of changes in healthcare commissioning and provision. Thematic analysis of 379 free-text responses yielded two thematic clusters. Cluster 1 describes the lived experience of citizens considering reforms to the NHS, depicting grief, mortality and fear in uncertainty. Cluster 2 explores where these affective responses may derive from by detailing conceptualisations of the NHS in the lived experience, describing how the NHS was experienced as a complex and embodied phenomenological object. Findings suggest people relate affectively to local commissioning practices, feeling a sense of loss when facing the degradation of 'their' NHS. We argue that an affective relational perspective centres important questions of silencing, voice-giving, meaningful engagement and ways of knowing that in turn impact the landscape of community health.

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**KEYWORDS**

affect, community health, empowerment, healthcare policy, marketisation, National Health System, qualitative analysis, service provision, thematic analysis

## 1 | INTRODUCTION

The British National Health Service (NHS) occupies a special place amongst health systems around the world for the driving values of delivering free, good quality care to all, solely on the basis of need. However, legislation has brought significant changes to the National Health System by increasing marketisation practices in healthcare provision, exemplifying global trends. By 'marketisation' we refer to the increasing involvement of private sector health providers in the delivery of health services. Legislation has increasingly emphasised public input into commissioning health services through various engagement mechanisms, although in practice, these commissioning inputs can be problematic (Walker et al., 2018). In mental health services, for example, 'engagement' has arguably disempowered already-vulnerable service users who are unable to deviate from managerial agendas or meaningfully contest strategic changes (Hui & Stickley, 2007; Rutter, Manley, Weaver, Crawford, & Fulop, 2004). Community psychology is inherently concerned with the ways in which given systems can facilitate or inhibit agency, power and oppression at the individual and collective levels. There is therefore a disciplinary imperative to interrogate and explore the psychological dimensions of this shifting context in healthcare commissioning and any resulting impact on the citizenry, taking the assumption that such practices have the potential to perpetuate community disempowerment (Kagan, 2011). To our knowledge, this task has not yet been undertaken, with the most adjacent research perhaps being an exploration of discourses around community hospitals (Jones, 2016). Taking a community psychological perspective on what might otherwise be considered strictly a social policy debate, we therefore aimed to identify and understand lay citizens' lived experience of changes in healthcare commissioning and provision in the South East of England in an era of increasing marketisation.

## 2 | CONTEMPORARY HEALTHCARE COMMISSIONING PROCESSES

We briefly describe national trends of healthcare commissioning before turning to the local context of the study. Since the early 1990s, there has been continual shift towards marketisation, with the introduction of pricing mechanisms and competition amongst healthcare providers said to increase efficiency and introduce innovative treatments (Exworthy, Powell, & Mohan, 1999; Zolkiewski, 2004). Healthcare providers are now expected to engage in entrepreneurial activity, balance budgets and engage in private care (Mays, Dixon, & Jones, 2011). NHS service provision has been opened to profit-making organisations and the private sector invited to finance new hospitals under Private Finance Initiative arrangements (Department of Health (DoH), 2006).

Most recently, the 2012 Health and Social Care Act (HSCA) aimed to augment prior focus on systems to extend opportunities for individual participation. Key features of the contemporary commissioning landscape include the replacement of Primary Care Trusts (PCTs) with General-Practitioner-led Clinical Commissioning Groups (CCGs). The Act embedded patient and public involvement within NHS research, funding and provision agendas, for example systematic engagement with Healthwatch England in every local authority area. Healthwatch England aims to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. However, numerous controversies have emerged concerning the commissioning process (Checkland et al., 2013; Walker et al., 2018). First, healthcare professionals report that their CCG policies do not reflect their own views and feel they have very little chance to impact policy decisions (Murphy, 2015). Second, service tendering has been routinely plagued by institutionalised secrecy through which these contracts are procured, awarded and performed with an overriding

focus on cost-efficiency (BMJ, 2015, 350: h14). Finally, and most crucially, the logic of marketisation has been extended towards public and patient involvement, with as-yet unexamined implications. We take the problematised implications of adopting a consumer-choice model for community involvement as a premise for our study.

### 3 | QUESTIONING THE MODEL OF PATIENT AND PUBLIC INVOLVEMENT

An arguably positive move of the HSCA was to embed within NHS commissioning emerging spaces for public involvement (DoH, 2012a, 2012b). This would enable citizens and policymakers to come together, with alignment between decisions and the public's views, or at least public accountability (Tsuchiya & Dolan, 2007). However, some have questioned whether the public's views are meaningfully contributing to policy or provision or whether the terms of commissioning are pre-empted and proscribed by the current infrastructure. Some have suggested that Healthwatch largely depends on a consumerist model of patient engagement, wherein citizens are treated as consumers of health services like any other private services (Hudson, 2015; Ocloo & Fulop, 2012; Walker et al., 2018). Powerful interests are well-attuned to agenda setting and defining problems in particular ways, as well as avoiding, side-lining or restricting participation to 'safe' issues where cultures of denial, secrecy, protectionism and fragmentation of knowledge and responsibility are often implicated in failures (Martin, McKee, & Dixon-Woods, 2015; Smith, 2006). An alternative orientation of public involvement might be the democratic or empowerment model that, having been used in social work practice and disability research, could instead underpin both public involvement and commissioning itself (Barnes & Cotterell, 2012; Beresford, 2000, 2013).

### 4 | INTRODUCING THE PRESENT STUDY

Like many places, the city of Brighton & Hove in South East England faced several significant health provision challenges in health and care planning at the time of this research, prompting an exploration of the efficacy of current commissioning practices. The Royal Sussex County Hospital had been placed in special measures. A local Clinical Commissioning Group had been rated as 'inadequate' by NHS England on five indicators including leadership, planning, finance, performance and delegated functions (Thomas, 2016). As well as transferring numerous ancillary and equipment provision services to commercial providers, a number of general practices had been closed or faced impending closure in the last 24 months. This negatively impacted community health provision: for example, patient transfers between GP practices were required with several practices in special measures, and the Patient Transport Services failed following transfer to a private contractor (Walker et al., 2018).

Within this context of exclusionary commissioning structures, the prioritisation of consumer orientations to healthcare and the marketisation of healthcare provision, the Brighton Citizens' Health Services Survey (BCHSS; Brighton Citizens' Health Survey, 2019) was undertaken as a piece of academic activism which might open up additional spaces for citizen engagement where existing spaces may be deficient, create knowledge around commissioning systems and provide an evidentiary platform to engage with policymakers through traditional and activist channels; Rhodes, Wright, & Pullen, 2018). We aimed to assess the awareness of commissioning choices and preferences of a wide range of residents in the South East of England with a wider goal of disrupting existing commissioning systems and informing viable alternatives. We did not share a particular vision of what these viable alternatives might be, nor a dedication to a particular policy outcome. However, within a community psychology framework, we maintained awareness of the problematic homogenisation of diverse citizens into a singular class of 'service users'. We similarly shared concerns over the possible implications of the marketisation of commissioning, provision and delivery upon democratic processes and the psychological well-being of the citizenry.

The study reported here specifically aimed to identify and describe the lived experience of citizens reflecting on healthcare commissioning practices representing a novel and urgent addition to research concerned with community

empowerment, public health and healthcare policy. In focusing on subjective experience, we articulate the latent and explicit meanings inherent in citizens' expressed views, in contrast to, say, policy preferences. This focus allows us to explore alternative orientations, ways of knowing and modes of public participation that have been minimised or silenced by existing policy discourses and exclusionary commissioning structures and to apply empirical work to the task of critically disrupting the status quo to redistribute power relations towards equality without a priori endorsing a particular political solution or affiliation (Kagan, 2011; Rhodes et al., 2018).

## 5 | METHOD

### 5.1 | Ethical approval

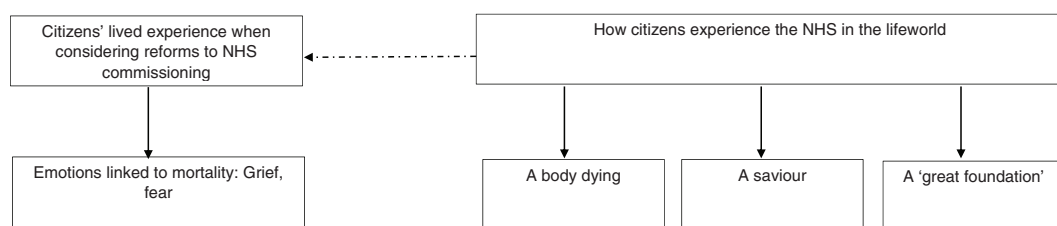
Ethical approval was obtained from the Tier 1 Ethics Committee of the School of Applied Social Science, University of Brighton on November 18, 2015. Participants viewed an information sheet detailing consent procedures, anonymisation, confidentiality, data protection, risks and benefits of the study prior to commencement. Informed consent was denoted through completion of the survey.

### 5.2 | Materials

The Brighton Citizens' Health Services Survey comprised an eight-question survey assessing citizens' appraisals of health commissioning, current commissioning issues and future commissioning plans, followed by a single free-text item inviting further comment. Surprising the research team, this closing item yielded a range of responses concerning what people thought and felt about commissioning processes. Analysis is here applied to this single free-text item, whereas statistical analysis of quantitative survey items is available elsewhere. The survey was designed in line with a wealth of critical literature suggesting that researchers' biases and subjectivity are not inherently diminishing the validity of the data collected and analysed (Gough & Madill, 2012; Madill, Jordan, & Shirley, 2000). A value-driven survey can be considered a valid measurement tool where researchers' fresh perspective on the issue is granted by on-going reflexivity and engagement with the literature and the data, which contribute to the trustworthiness and reliability of the analysis (Shenton, 2004; Thuo, 2013). All data are freely accessible via the BCHSS website, enabling external inspection, with example quantitative survey items including Likert-style responses to, for example, whether health companies should make a profit from people's health problems, levels of concern over awarding the contract for NHS 111 non-emergency services to a private provider, levels of concern of proposed cuts of £21.9 million from the Adult Social Care budget, whether there should have been a full consultation on awarding a contract for referral managements to a private company (Optum), and preference for being treated by the NHS compared to a private company personally or in the case of provision of Health Visiting, School Nursing and other children's community health services. This qualitative study does not aim to triangulate, confirm or interpret the quantitative findings, such that these items are presented here for context only.

### 5.3 | Participants and recruitment

We collected a convenience sample of members of the general public. Sampling activities included convenience sampling in the city centre; circulation amongst residents' associations, church groups, all political parties and two local universities; and social media dissemination. All respondents were over 18 years old. Of 439 responses to the free-text question, 60 were omitted from the final analysis for a final 379 responses. Omitted responses were comprised of thank you, identifiable disclosures of residence and allegations of bias against privatisation. The full BCHSS dataset is publicly available online, with the textual data to which this analysis is applied being accessible at <http://>



**FIGURE 1** Phenomenologies of NHS commissioning practices

[blogs.brighton.ac.uk/bchss/brighton-peoples-thoughts-and-concerns-from-the-first-survey/#.XkvDdmj7Q2w](https://blogs.brighton.ac.uk/bchss/brighton-peoples-thoughts-and-concerns-from-the-first-survey/#.XkvDdmj7Q2w). The data were collected between May and July 2017 and analysed in Spring 2018.

## 5.4 | Analytical procedure

An inductive thematic analysis (Braun & Clarke, 2006) inspired by the epistemological stance and attention to lived experience of descriptive phenomenology (Davidsen, 2013) explored how NHS commissioning processes were experienced by citizen respondents. Thematic analysis flexibly permits a range of epistemological approaches as researchers navigate through a series of decision points to arrive at a coherent and rigorous analytical approach. We employed a phenomenological epistemological stance that oriented to both latent and explicit meanings within the text (Giorgi & Giorgi, 2008). Analysis focused not on uncovering citizens' objective, verifiable 'reality' but also on generating a descriptive account of how they subjectively experience their 'reality'. We developed themes according to their apparent significance (Braun & Clarke, 2006). Although qualitative analysis is an iterative process, we describe our steps sequentially for simplicity. After reading and re-reading the data, the first (R.G.) and second (A.Z.) authors performed a separate line by line coding and thematising. C.W. performed a second coding of 10% of responses. The coding, sub-themes and themes were then discussed, interrogated and challenged by all the authors during periodic meetings, and a final thematic map was agreed (see Figure 1). First, we determined that two main phenomena (or thematic clusters) were exemplified in respondents' experiences. Within these, four main themes were identified as independent units of meaning, although they were inevitably interconnected in the respondents' words. In Figure 1, we speculate that the second phenomenon and related themes are likely to underpin the first phenomenon and how it is experienced, represented by a directional arrow from Cluster 2 to Cluster 1.

## 6 | ANALYSIS AND RESULTS

Analysis revealed that citizens experience emotions of grief and fear when considering reforms to NHS commissioning, evoking their own mortality and that of the NHS. Citizens may implicitly experience the NHS in a variety of ways beyond that suggested by the dominant consumer model of engagement, three of which are identified and described here: as embodied and dying; as a saviour; and as a national treasure.

### 6.1 | Cluster 1: Lived experience of citizens considering reforms to the NHS

#### 6.1.1 | Grief, mortality and fear in uncertainty

Participants often used highly emotive language to describe their thoughts about the consultation process. With rare exception (one mention of feeling 'happy' about privatisation), participants expressed a complex mix of negative

emotions coalescing around a sense of impending grief. Most common were expressions of concern, well exemplified by P3 'I am very concerned about the access of private companies to health care', P29 'I have grave concerns for the future of the NHS' and P54 'I am extremely concerned about privatisation of the NHS'. Others commonly reported feeling 'horrified' (i.e. P378 'I am horrified at what is happening to the health service') and 'appalled' (i.e. P282 'I am appalled at the back door privatisation of the NHS'); finding the treatment of the NHS 'disgraceful' or 'shameful' (i.e. P340 'Access to health care should not be the prerogative of the wealthy. We are operating like a 3rd world country and it is a disgrace. Shame on those responsible') and being 'worried', 'nervous', 'very afraid' and 'alarmed' (i.e. P427 'I also worry about losing the joined up approach to care that the NHS offers. It is a remarkable service which we are very lucky to have and I would be very sad to see it slowly eroded away').

A minority of participants referred to bodily responses of 'disgust'. For example, P335 noted: 'It makes me sick watching what the cuts and top down restructuring has done to our wonderful service!' This brief extract vividly depicts a feeling of looking on helplessly as a tragedy unfolds. Restructuring was experienced by P335 as a series of mortality-threatening acts against the NHS, which is itself considered to be in some way belonging to the participant ('our wonderful service'), demonstrating the personal nature of P335's complex feelings of loss, disgust and outrage—not unlike a relative watching on as a doctor tends to their loved one.

For some participants, this fear left them 'intensely sad' over the decline of the NHS and 'seriously scared' about the future (i.e. P201 'I hope something can stop the rampant trashing of our NHS. I am seriously scared about what is going on'), evoking grief reactions (i.e. P232 'The on-going privatisation of UK health care services [...] will result in the destruction of the NHS. This will be a tragic and painful outcome for all of us living in the UK'). Some vividly related fears for their own mortality or that of others, with a sense that death could knock at their door in the indeterminate future. As P69 states 'If there is anything no one can be sure, is when disease will knock on your door. Then, you'll want to be reassured that you have the best care, and not how can a private company save money with your treatment'. Similarly, P367 wrote: 'I totally depend on the NHS for my life until I die [... I have] become a non-profitable patient and I would be left to die if the health providers look for profit in what they do'. For these participants, decisions about healthcare funding and provision are seen as a matter of life and death, at worst fearing being 'left to die' when service motives are de-emphasised. As also exemplified in P343's words 'This is a disaster unveiling before our eyes and if this isn't stopped it leads the way to the end of our NHS'. This fear complements the indignation and concern described above with a counterpoint of dependency, despondency and a bleak awareness of one's own mortality underpinning contemplation of the demise of the NHS.

## 6.2 | Cluster 2: Where does this loss stem from? Conceptualisations of the NHS in the lived experience

### 6.2.1 | 'Starved' and 'mauled': The NHS as embodied and dying

The NHS was sometimes represented as an embodied being whose decline could be or was consequently envisaged using graphic and evocative death metaphor. This thematic lens is particularly significant given the paucity of alternative metaphors used—when latent meanings were called upon, they generally evoked the body. The Government was described as 'twisting the NHS's arm and crippling it' (P417) and private companies as 'bleed [ing] the NHS dry' (P265), conveying a sense of tortuous pain to the NHS body. Participants did not overtly employ a narrative referring to the ending or phasing out of the NHS, making this use of a death narrative by a significant minority of participants particularly interesting. Modes of death varied but terms of violence generally characterised the decline. The NHS was depicted as 'being starved (P173)' and 'being fragmented, starved of funds and set up to fail (P93)', envisioning a slow and deliberate withdrawal of needed nutrients ('starving it of funds' P325). The NHS was subject to 'rampant trashing' (P201), was 'decimated & mauled' (P105) and subject to destruction through 'salami slicing' (P118). Occasionally, specific actors were named as responsible for

'finishing off' (P192) the NHS, mostly the 'government' (P417), creating a sense of malevolent force and impending doom.

The embodied characterisation of the NHS carried through to envisaging the NHS as a body in need of protection and nurture. This ranged from claims to 'save our NHS' (P359) to noting that 'we should value and nurture the service we already have' (P427). Even among routinised claims or slogans to 'save' the NHS, the NHS was classed as an entity that belonged to the participant ('our') or was experienced in personal relationship to the participant: 'The NHS saved my life it has my full support and deserves saving itself.' (P342). Here, P342 conveys gratitude for the life-saving support they received, placing their policy opinion in an emotive framework. P342 demands reciprocal treatment for this heroic rescue. The extract suggests that participants experience the NHS as an embodied entity in need of the same medical assistance that it has provided ('deserves saving itself'). If the NHS is a body that is dying, it is also a body in need of nurturance and protection, not unlike the patients it serves.

### 6.2.2 | 'It has saved my life': The NHS as saviour

Even as the NHS was portrayed as a body in need of rescue, it could also be experienced as one who had previously been relied upon for rescue (sometimes, as with P342, by the same participant). As with the sense of the NHS as embodied, there were links between how the participant experienced their own medical journey and the wishes and needs they imparted on the NHS. Participants repeated that the NHS 'saved my Life' (i.e. P42, 262, 333, 342) and that they furthermore 'owed [their] life' (P219) to the NHS. A religious tint could be observed in some statements (e.g. P331 urging the reader to 'keep faith with a public NHS'), endowing their pleas for public funding and provisioning with a fervent gratitude towards a saviour-like entity, as in P42's statement: 'protect the NHS. It has saved my life.'

Beyond simply providing services, the NHS was depicted as enacting miracles, as with P63: '17 years ago I was diagnosed with an "incurable" cancer, thanks to dedication and hard work by the NHS I am now cured. I think the results would have been very different under a profit-making regime.' The curing of the incurable creates a sense of the miraculous. Although P63 credits the 'dedication and hard work' of staff, they qualify that a 'profit making regime' could create no such miracles. Crucially, the miracle is portrayed as specific to a public healthcare system, not other possible features of their care.

### 6.2.3 | A 'great foundation': The NHS as a source of national pride

The NHS was commonly experienced as a matter of national pride ('The NHS is one of the great foundations of Britain' P420), creating a sense of public ownership over 'the most important asset we have (P365)' and 'the greatest asset of this country (P125)'. However, the NHS was not valued strictly as a financial asset—rather, it was imbued with connections to values, intangible wealth and generational inheritance. Some participants experienced the NHS within the context of historical inheritance: 'Please keep our NHS, I paid for it as did my parents, it's ours and it's not for sale (P39)'. Here, the NHS is viewed as a common asset or heirloom, passed down through the generations and maintained within the family. Although participants sometimes evoked nostalgia, this did not necessarily mean they were wedded to the past at the expense of current functionality. As P66 said, 'The NHS undoubtedly could make savings if it were organised more efficiently and it's services were correctly accessed by the public', nonetheless 'NHS Health care should NEVER be a commercial enterprise' exactly because 'It was set up post war as a public service to enable those without means to access first rate health care'. The refusal of a profit orientation can be understood by considering how the NHS is seen in terms of the intangible worth of the nation ('The NHS is what makes this country a civilised country' P187), evoking pride not unlike other distinctive institution such as the monarchy. The NHS was characterised as a 'national treasure' by P344, who continued: 'This is one of the many things we have

that put the Great into Great Britain', linking the NHS to founding national myths. This is echoed by others urging that 'the UK should be proud and treasure this service' (P333) and adapting slogans used to support that other founding institution of the country, the monarchy ('Long live the NHS', P334).

Acknowledging the historical meaning of the NHS foundation by affirming that 'the mission of the NHS to provide the best possible healthcare to the UK population' (P145), respondents claim that 'private health care is an abomination and against everything that the founders of the NHS stood for' (P4). NHS commissioning is perceived as a betrayal of the lived experience of the NHS foundational values.

## 7 | DISCUSSION

A phenomenologically minded thematic analysis of NHS commissioning practices gives voice to ways in which citizens feel, interpret and engage with changing healthcare commissioning practices. Crucially, citizens *relate* to healthcare provision, delivery and commissioning practices, rather than operating strictly as rational actors in an economic exchange or democratic framework. Many participants held an 'affective relational' orientation to commissioning processes whereby the NHS is important to peoples' ideas about 'local identity, sense of place and where the physical incarnation of the NHS and its values...has meaning beyond service use' (Jones, 2016). Relating was affective, impactful and troubling, tapping into implicit meanings of mortality, services and nationhood that are not currently held within local commissioning and consultation processes. This is, to our knowledge, the first empirically based argument for including an affective-based element in health policy change processes.

### 7.1 | Identifying and describing an affective relational perspective

Our study provides a perspective that unrepresented in mainstream accounts of understanding public responses to healthcare policy but which is informed by community psychology's dual concerns with exploring relationships between structures and individuals and identifying implications of the distortion of these relationships for community health and empowerment. Sensitivity towards lived experience created space to access aspects of participants' 'realities' that are masked or omitted from metrics. An affective relational perspective challenges dominant models of commissioning processes by suggesting that, for some citizens at least, their engagement with consultations has emotive underpinnings and is driven by implicit, relational meanings. This is surprising only to highlight the ways in which citizens' subjectivities have been written out of the current structure of public input into commissioning. The HSCA promised greater voice for patients and new mechanisms for local accountability (DoH, 2012a, 2012b). By this logic, citizens should feel engaged, empowered and involved—yet our data suggest many do not. To dismiss the affective component in citizens' debates is to engage in a fundamental, problematic silencing.

Although citizens may not articulate their concerns within the structured frameworks and unemotional language expected for consultations, these concerns are nonetheless an important dimension of their experience of healthcare commissioning and may have unexplored implications for community health. People fear for their own lives and those of their loved ones and seem to transfer these emotions onto the NHS as embodiment of a common fate. This fear may be rooted in real-life experiences of citizens struggling to access routine and lifesaving services (Murage, Crawford, Bachmann, & Jones, 2016; van Leeuwen et al., 2014). Although examples of anger and frustration in local commissioning and healthcare policy processes are not unheard of (e.g. Checkland, 2013, 346: f189; Malacrida & Duguay, 2009), our findings demonstrate a full range of emotional responses and articulate a phenomenologically coherent rationale for those responses, such that it becomes increasingly problematic to dismiss such reactions as invalid due to their affective content.



## 7.2 | Silencing citizens in the age of austerity

Although the implications of such exclusion for community health are beyond the scope of this analysis, the wider context of austerity provides a sense of urgency. The metaphor of death so frequently recalled in the data reflects a tangible, observable degradation of citizens' own health and the health of their families. Austerity measures in place in the United Kingdom have been shown to significantly erode citizens' mental health, life expectancy and growing inequalities (Barr, Kinderman, & Whitehead, 2015; Bhandari, Kasim, Warren, Akhter, & Bambra, 2017; Buck & Maguire, 2015; Maynard, 2017). Citizens' perceived relationships to their localities, including their capacity to exercise collective action locally, can have important implications for well-being (Carbone, 2019). The 'death of the NHS' experienced by the Brighton and Hove citizens has a sinister parallel with the peak of mortality experienced in England and Wales in 2015 (Green, Dorling, & Minton, 2017). An application of an affective-relational perspective echoes approaches finding that consultations in neighbourhood policy are inextricably linked to emotions around place and community relationships and that these complexities are similarly minimised or silenced within those policy processes such that citizens feel concerned, excluded, distanced and marginalised; Hammond et al., 2017; Jupp, 2013).

In the present study, not only is the NHS bound up in lived experience with the body but also its acts of deliverance are intertwined with characterisation as a public service, staffed by persons driven by service—posing tension when policy changes shift services towards the private sector. The interpretation of the NHS as a saviour and a foundational feature of society recalls the Arendtian notion of authority, with troubling implications for how minimisation of affect and relationality create barriers to democratic engagement. Authoritative systems educate new generations into their culture and permit endurance of cultural values across time (Arendt, 1961). It is perhaps surprising that a public healthcare system is deemed a foundational institution when neoliberal discourse and marketisation of health seem the norm globally (Değirmencioğlu & Walker, 2015; Prince, Kearns, & Craig, 2006). But this being so, it is understandable that the prospect of losing the NHS echoes the destruction of a 'great foundation', the attack to a longstanding 'saviour' and the slow but relentless mutilation of a 'body dying'. This relationality has been echoed in discourses of UK hospitals. Hospitals, existing at a fraught juncture between life and death, where the focus is on intimate or even invasive interpersonal and technological access to the body, are constructed by the public not simply as buildings for healthcare delivery but as expressions of the NHS and its values (Jones, 2016).

The data therefore pose concerns about the implications of commissioning decisions for erosion of social cohesion, diminished confidence in public and Government institutions and disbelief in shared national myths, as well as challenges to local-level democracy. This suggests that alternative models of engagement emphasising a democratic contribution to the decision-making process have been omitted, despite parallel moves towards public involvement, echoing debates over the motivations underpinning reforms to commissioning. The HSCA has been selectively characterised as an application of neoliberal ideology using the financial crisis to implement top-down reorganisation of the NHS or to support xenophobic policies limiting access to care (Alderwick, Dunn, McKenna, Walsh, & Ham, 2016; Shahvisi, 2019; Skidelsky, 2015; Thornton, 2016). Whatever the motivations of the legislation, our findings suggest citizens are questioning the legitimacy and feasibility of public service motivation within healthcare and are grappling with troubling implications of shifting motivations underpinning the nature, quality and accessibility of care. This suppression is problematic given the dedication of the broader citizenry to treatment by the NHS and to a refusal of a profit motive as a legitimate element of healthcare provision, opposing the trending policy direction of healthcare commissioning.

Our findings suggest that certain ways of knowing and modes of public participation have been excluded from commissioning practices. That which cannot be measured has not been part of policy. Health systems have been framed by an increasingly prescriptive and centrally driven set of performance metrics (Currie & Suhomlinova, 2006). Kerasidou (2019) argues that the tension between metric and value has effectively displaced a norm of empathy with a norm of efficiency in austerity-era NHS A&E departments, as doctors and nurses feel that increasing emphasis on efficiency has 'curtailed their clinical judgment and hindered the practice of core professional values such as

patient-centeredness, empathy and compassion' (p. 9). Health institutions tend to have a limited concept of accountability due to the dominance of these prescriptive audit regimes working in combination with central command structures and vertical control, which may account for the very few examples of citizen participation leading to improvements in services or changes in policy (Smith, 2006). Whatever the reason, our findings suggest that dominant readings amongst the public in South East England of the current commissioning process are characterised by a profound lack of knowledge of decision making, high levels of suspicion for the nature of these decisions and their underlying political motivations and feelings of grief and fear for the future of a much-loved national institution.

Although the acknowledgement of an affective relational orientation to healthcare commissioning does not dictate a particular set of policy choices or political outcomes, our findings suggest that within the citizenry surveyed there is a desire to move towards or retain policies that privilege a service motive amongst providers, retain some degree of public accountability and ownership and address the fears and anxieties introduced by prolonged austerity measures. However, rather than specifying a particular menu of policy choices, the strength of this research is in articulating an urgent need to generate affective relational knowledge more systematically, and to include this knowledge meaningfully within commissioning systems, lest a problematic exclusion of citizenry be perpetuated indefinitely.

### 7.3 | Contextualising the study

This project arose from the need to analyse the overwhelming volume of rich data generated by a simple open-ended question closing the BCHSS surveys, perhaps speaking to citizens' appetite for engaging in such discourse—indeed 92% of respondents to the survey indicated that they would have preferred a full public consultation on recent matters of healthcare commissioning, when no such public consultation did occur. The qualitative analysis presented here was conducted independently to the statistical analysis of the closed BCHSS items, with the two primary coders here having minimal contact with the statistical analysis. This is not strictly a phenomenological study, but uses a thematic analytic approach guided by epistemological concerns towards lived experience. The sampling framework was not fully representative of the city, despite attempts to sample across socioeconomic strata and in different locations.

### 7.4 | Recommendations for future practice, research and policy

The implications of exclusion—not least the omission of alternative modes of engagement grounded in non-consumerist frameworks—are unknown, but potentially troubling. To continue without reflecting on those silences would perpetuate problematic modes of inclusion. Our findings speak to the imperative of giving voice to, and understanding, alternatives ways of knowing. In order to empower and enfranchise communities threatened by shifting landscapes of healthcare and provision, policymakers should seek to include affective-relational responses in commissioning processes, bringing psychology into policy. We recommend canvassing affective responses, shifting policy discourse to include affective responses and restructuring consultation systems to facilitate more relational and participatory modes of knowledge generation to sit alongside expert technical knowledge in line with calls for shared decision-making and relational models of leadership and sharing medical knowledge within healthcare settings (Bonham et al., 2009; Fulop & Mark, 2013; Légaré et al., 2013; Trezona, Dodson, & Osborne, 2017). We recommend explicitly acknowledging the significance and meaning attached to fundamental institutions such as the NHS, or its international equivalents, and striving to align commissioning with those meanings by, for example, favouring not-for-profit providers and celebrating public service motivation. Future research might continue to explore affective understandings of public institutions in the lived experience, applying an affective relational perspective to understanding citizens' responses in different localities and/or across different policy foci.

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